GREENVILLE FAMILY DENTISTRY

PATIENT REGISTRATION

Patient Information

First Name: _____ Last Name: _____ Middle Initial: _____

Preferred Name: _____ Patient Is: ☐ Policy Holder ☐ Responsible Party

Address: _____

City: _____ State/Zip: _____

Home Phone: _____ Cellular: _____ Work: _____

Email Address: _____

I would like to receive correspondences via (check all that apply): ☐ E-mail ☐ Text ☐ Phone Call

Sex: ☐ Male ☐ Female Date of Birth: _____ Age: _____

Social Security #: _____ State/Driver's License #: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired Student Status: ☐ Full Time ☐ Part Time

Preferred Pharmacy: _____ Phone #: _____

Preferred Hygienist: _____

Emergency Contact: _____ Phone #: _____

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____

City: _____ State/Zip: _____

Home Phone: _____ Cellular: _____ Work: _____

Email Address: _____

☐ Responsible Party is the Policy Holder for Patient ☐ Primary Ins. Policy Holder ☐ Secondary Ins. Policy Holder

Primary Dental Insurance Information

Name of Insured: _____ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Social Security #: _____ Insured Birth Date: _____

Employer: _____ Address: _____

City: _____ State/Zip: _____

Insurance Company Name: _____ Customer Service #: _____

Group #: _____ Address: _____

City: _____ State/Zip: _____

Secondary Dental Insurance Information

Name of Insured: _____ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Social Security #: _____ Insured Birth Date: _____

Employer: _____ Address: _____

City: _____ State/Zip: _____

Insurance Company Name: _____ Customer Service #: _____

Group #: _____ Address: _____

City: _____ State/Zip: _____

X_____ _____

Signature of Patient (parent or legal guardian if minor) Today's Date